

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

86001

6018

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Michaels</i>		c. LENGTH OF STAY IN 1b <i>life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x St. Michaels</i>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Andrew J. Barnett</i>		First	Middle	Last	4. DATE OF DEATH Month <i>5</i> Day <i>12</i> Year <i>1959</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>C01</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/1/75</i>		9. AGE (In years last birthday) <i>84 yrs.</i>	IF UNDER 1 YEAR Months <i>84</i> Days <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>waterman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Oyster</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Barnett</i>		14. MOTHER'S MAIDEN NAME <i>MARIA Turner</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>220-01-8229</i>		17. INFORMANT <i>Hester Dunn</i>		Address <i>St. Michaels Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i>		Congestive Heart Fail		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Arteriosclerotic Cardiovascular Dis.</i>		Arteriosclerotic Cardiovascular Dis.					
(c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Atrial Fibrillation</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <i>Baltimore</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>3/1/59</i> to <i>10/1/59</i> , 1959, that I last saw the deceased alive on <i>10/2/59</i> , 1959, and that death occurred at <i>600 St. Michaels</i> , M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Baltimore, Md.</i>	
ACTUAL SIGNATURE <i>R. Lane Wroth</i>		DATE SIGNED <i>5-13-59</i>					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/18/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Michaels Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>St. Michaels, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Bushnell, Carlton, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>MAY 19 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur & Turner</i>	

ESTIMACIONES DE LA PRODUCCION
CANTIDAD DE SEGURO

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG242 5-19-59 et

06002

6004

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN lb <u>8 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTON Memorial Hosp.</u>		e. STREET ADDRESS <u>Globe Road</u>		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>Dennis</u>	Middle <u></u>	Last <u>Brice</u>	4. DATE OF DEATH <u>Aug. 1966</u>	Month <u>5</u>	Day <u>1</u>	Year <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 1899</u>	9. AGE (In years last birthday) <u>59</u> yrs.	10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Term laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Currie Brice</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Sampson</u>		Address <u>Mrs. Maggie Sampson, Easton, Md.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <u>Cerebral thrombosis</u> (b) DUE TO <u>Cardio megaly</u> (c) DUE TO <u>Hypertension</u>	
						INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>12 p.m.</u> Day <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <u>7:15 P.M.</u> M. from the causes and on the date stated above.		ACTUAL SIGNATURE <u>E. C. Schmidt</u>		ADDRESS (Street, city or town, state) <u>219 S. Washington St. 6 May 59</u>		DATE SIGNED <u>6 May 59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/14/59</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>New Chapel Cemetery</u>		22d. LOCATION (City, town, or county) <u>Easton R+3, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashed</u>		ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6005 CERTIFICATE OF DEATH

Reg. Dist. No.

06003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY TALBOT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN lb 22 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FEDERALSBURG		d. STREET ADDRESS HOME OAK BEACH, NEW YORK 69 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL		d. STREET ADDRESS HOME OAK BEACH, NEW YORK 69 X-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First GEORGE W. B.	Middle	Last BURR	4. DATE OF DEATH MAY 21 1959	Month	Day	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 10 1892	9. AGE (In years lost birthday) yrs. 67	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUILDER AND CONTRACTOR		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE W. BURR		14. MOTHER'S MAIDEN NAME MARY DELIA DURYEA		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT WILMURT B. LINKER, NEW YORK, N.Y.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. nodes -	
						INTERVAL BETWEEN ONSET AND DEATH 1 Mo	
DUE TO (b)							
DUE TO (c)		Carcinoma of large bowel					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 21 May 59 , 19 59 , to 21 May 59 , 19 59 , that I last saw the deceased alive on 20 May 59 , 19 59 , and that death occurred at 5:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Thorston Harrison		M.D.		ADDRESS (Street, city or town, state) Chestertown, Maryland		DATE SIGNED 21 May 59	
PHYSICIAN'S NAME (Type) THORSTON HARRISON							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 23, 1959		22c. NAME OF CEMETERY OR CREMATORY HILL CREST CEMETERY		22d. LOCATION (City, town, or county) (State) FEDERALSBURG, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Grangham Son, Federalsburg Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 26 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6006 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06004

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Talbot		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Easton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mem Hosp		d. STREET ADDRESS Talbot St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Alice		BESSIE	Cahall
4. DATE OF DEATH		Month	Day
		May	4
		1959	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
f		IN	B. DATE OF BIRTH 1-16-10
9. AGE (In years last birthday) 49 yrs.		10. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME Rosa V. Hartsock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-18-4808	
17. INFORMANT Hosp. records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Coronary Occlusion	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		DATE SIGNED 5-4-59	
ACTUAL SIGNATURE <i>Louis Weltz</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) WELTZ			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 7, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM Greensboro Cemetery		22d. LOCATION (City, town, or county) (State) Greensboro, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE MAY 7 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Form 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMJ. Page 5 may be retained by your office.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE

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FBI - NEW YORK

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6019

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06005

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CALVERT					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NR TILGHMAN		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUNDERLAND		d. STREET ADDRESS 04X-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First LEROY	Middle CONTEE	Lost	4. DATE OF DEATH MAY 31 1959	Month MAY	Day 31	Year 1959	
5. SEX MALE		6. COLOR OR RACE COL	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH MAY 1916	9. AGE (in years last birthday) 43 yrs.	IF UNDER 1YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME WILLIAM CONTEE				14. MOTHER'S MAIDEN NAME IDA JACKSON					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT WM CONTEE			
						Address SUNDERLAND MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACCIDENTAL DROWNING DUE TO Conditions, if any, which gove rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) BODY RECOVERED OFF TILGHMAN JUNE 5, 1959								INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL OFF CABIN CRUISER IN CHESAPEAKE BAY				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour p. m.		Month, Day, Year 5-31 1959	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) CHES. BAY		20f. (City or town) Sharks Is. Talbot (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								DATE SIGNED 6-5-59	
ACTUAL SIGNATURE <i>Lewis O'Weltz</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) WELTY									
22a. BURIAL/CREMATION REMOVAL (Specify) June 6, 59		22b. DATE THEREOF June 6, 59		22c. NAME OF CEMETERY OR CREMATORIUM St. Edmund		22d. LOCATION (City, town, or county) Sunderland		(State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE P.T. Sewell, Owner Fred,				ADDRESS		24a. REC'D BY REGISTRAR JUN 9 '59		24b. REGISTRAR'S SIGNATURE C. Williams	

MANUFACTURED
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6007 CERTIFICATE OF DEATH

Reg. Dist. No. 06006

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Md.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS					
Fulton		15 days		Federalburg		101 S. Main St.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Memorial		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year			
Allison		A	Covey		May	1	1959				
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Male		White		Jan. 1 1881		78 yrs		Sewer Worker	Retired	Md.	U. S. A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Andrew T. Covey		Sally Hubbard									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
no		44-1234567		Harvey W. Miller		Federalburg, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nephritis</u> DUE TO <u>Unknown</u> INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <u>Chronic pyelonephritis</u> (c) <u>Obstructive uropathy - prostatic hypertrophy</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>March</u> , 1959, to <u>5/1</u> , 1959, that I last saw the deceased alive on <u>April 30</u> , 1959, and that death occurred at <u>2:05 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)									
ACTUAL SIGNATURE <u>Robert W. Trevor</u>		M.D.		202 Dover St.						DATE SIGNED <u>5-5-59</u>	
PHYSICIAN'S NAME (Type) <u>Robert W. Trevor</u>		ADDRESS <u>Easton, Md.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 4, 1959</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Hillcrest Cemetery</u>		22d. LOCATION (City, town, or county) <u>Federalburg, Md.</u>		(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey W. Miller</u>		ADDRESS <u>Federalburg, Md.</u>		24a. REC'D. BY REGISTRAR <u>DAMAY 11 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Trevor</u>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06008

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. CITY OR TOWN <i>Talbot</i>	6020 MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tieghman</i>	c. LENGTH OF STAY IN lb <i>Life</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tieghman</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>Tieghman</i>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

3. NAME OF DECEASED (Type or print) <i>Carroll A. Tremain</i>	First	Middle	Last	4. DATE OF DEATH Month <i>5-</i>	Day <i>13-</i>	Year <i>1959</i>
5. SEX <i>M.</i>	6. COLOR OR RACE <i>N.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	DATE OF BIRTH <i>March 20, 1870</i>	9. AGE (In years last birthday) <i>89</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Watermen</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Cyber</i>		11. BIRTHPLACE (State or foreign country) <i>Caliborne Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Vincent Tremain</i>		14. MOTHER'S MAIDEN NAME <i>Wilhelmina Melvin</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. <i>None.</i>		17. INFORMANT <i>May Edna Tieghman</i>		Address <i>Tieghman Rd</i>

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>	<i>10 years</i>
DUE TO <i>Chronic bronchitis but desire</i>	<i>10 years</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO <i>Alimentary cystitis</i>	<i>10 years</i>
(c)	<i>12 years</i>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
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20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D.</i>	20f. (City or town) <i>Tieghman</i>	(County) <i>Talbot</i>	(State) <i>Md.</i>
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21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M. from the causes and on the date stated above.
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ADDRESS (Street, city or town, state)
Tieghman Rd, Talbot, Md.

DATE SIGNED
May 15, 1959

ACTUAL SIGNATURE <i>John J. Reeser</i>	PHYSICIAN'S NAME (Type) <i>John J. REESER</i>
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22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>May 15, 59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Tieghman Mts</i>	22d. LOCATION (City, town, or county) <i>Tieghman</i>	(State) <i>Md.</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Reed More Tieghman</i>	ADDRESS <i>1600 N. Charles St., Baltimore, Md.</i>	24a. REC'D BY REGISTRAR <i>John S. Evans</i>	24b. REGISTRAR'S SIGNATURE <i>John S. Evans</i>
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06007

Reg. Dist. No.

6008 CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN /b/ <u>5HRS. 20mins</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <u>BABY</u>	Middle <u>BOY</u>	Last <u>FOUNTAIN</u>	
4. DATE OF DEATH	Month <u>MAY</u>		Day <u>26</u>	Year <u>1959</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>MAY 26 1959</u>	9. AGE (In years last birthday) yrs. <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>CLARENCE COLLISON</u>		14. MOTHER'S MAIDEN NAME <u>RUTH FOUNTAIN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		Address <u>MOTHER - GOLDSBORO, MD.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)		<u>Intra cranial Hemorrhage</u> <u>Prematurity - 1st 65</u> <u>6 hours</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-26</u> , 19 <u>59</u> , to <u>5-26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-26</u> , 19 <u>59</u> , and that death occurred at <u>7A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>John S Baybott M.D. 205 Eagle Ave. Easton Md 6455</u>		
ACTUAL SIGNATURE <u>John S Baybott</u>	DATE SIGNED <u>6-4-59</u>			
PHYSICIAN'S NAME (Type) <u>JOHNE Baybott</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Incinerated</u>	22b. DATE THEREOF <u>5/28/59</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Memorial Hospital</u>	22d. LOCATION (City, town or county) <u>Easton Md</u>	(State) <u>-</u>
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
			DATE JUN 8 '59	<u>Arthur S. Evans</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6021 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06009

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Trappe		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1307 Greenmount Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First JOHN	Middle W	Last FRIEND	4. DATE OF DEATH Sept. 16, 1921	Month May	Day 12	Year 19 59
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1921	9. AGE (In years last birthday) 39	10. IF UNDER 1YEAR Months 37	11. IF UNDER 24 HRS Days 37	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not employed	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Oklahoma	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Richard C. Friend	14. MOTHER'S MAIDEN NAME Edna Stanley
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or, unknown) <input type="checkbox"/>	16. SOCIAL SECURITY NO 213-18-7694	17. INFORMANT Mrs Clinton Ruth Charlotte, N. C.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning, found drowned DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found drowned		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20c. TIME OF INJURY Hour a. m. p. m. 5/12/59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Trappe Creek	20f. (City or town) nr. Trappe	(County) Talbot	(State) Md.
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21. I certify that I had charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .					
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ACTUAL SIGNATURE 	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 5/15/59
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/18/59	22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cem.	22d. LOCATION (City, town, or county) Baltimore, Md.	(State)
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23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Inc.,	ADDRESS 1217 St. Paul St.,	24a. REC'D BY REGISTRAR MAY 20 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Krause
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FOR STATE
HEALTH DEPT.MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
6009 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06010

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for 1 year by the State Board of Health.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
+ Talbot		a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
EASTON		D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
Memorial Hospital		1	
f. IS REL. DENSE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
Clarence		Month Day Year	
First	Middle	Month	Day
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH	8. AGE (In years last birthday) <input type="checkbox"/> IF UNDER 1 YEAR 55 yrs. Month Days Hours Min.
Male	Col	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 12-23-1903	9. AGE (In years last birthday) <input type="checkbox"/> IF UNDER 24 HRS. 55 yrs. Month Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
truck driver		construction	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
George Green		Leah Coleman, Leah	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		E 73-12-504	
17. INFORMANT		Address	
Mary Etta Green, Oxford		Oxford	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		None	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <i>Louis Weltz</i>		DATE SIGNED 5-29-59	
EXAMINER'S NAME (Type) <i>Weltz</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION BURIAL (Specify) Burial		22b. DATE THEREOF 5/30/59	
22c. NAME OF CEMETERY OR CREMATORIAL Richards Cem.		22d. LOCATION (City, town, or county) Trappe	
(State)		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Smith, Weston, Md.</i>		ADDRESS	
24a. REC'D BY REG. STAR JUN 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6010 CERTIFICATE OF DEATH

06011

Reg. Dist. No.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be torn off for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>216 - 17th St</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Baltimore</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Maryland Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		d. STREET ADDRESS <i>11 East Street</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>John J. S.</i>	First <i>J</i>	Middle <i>J</i>	Last <i>S</i>	4. DATE OF DEATH Month <i>May</i>	Day <i>10</i>	Year <i>1959</i>					
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 7 1874</i>	9. AGE (In years last birthday) <i>64 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm Tenant</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>71 SA</i>					
13. FATHER'S NAME <i>Edward S.</i>		14. MOTHER'S MAIDEN NAME <i>Lucy Moran</i>		Address <i>Clara V. Slaughter Centerville Maryland</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-14-8676</i>		17. INFORMANT <i>Clara V. Slaughter</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart failure</i>		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>An embolism of a previously existing arteria</i>		DUE TO <i>(b)</i>	DUE TO <i>(c)</i>								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>219 S. Washington St.</i>		(County) <i>Baltimore</i>	(State) <i>Md.</i>		
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <i>5:45 A.M.</i> from the causes and on the date stated above.											
ACTUAL SIGNATURE <i>E. C. H. Schmitt</i>		ADDRESS (Street, city or town, state) <i>219 S. Washington St. Baltimore</i>								DATE SIGNED <i>May 14 1959</i>	
PHYSICIAN'S NAME (Type) <i>E. C. H. Schmitt</i>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>May 13 - 5:45 A.M.</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Woodlawn Memorial</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i>		(State) <i>Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>James S. Butler of Butler Bros., Centerville Md.</i>		ADDRESS <i>11 East Street</i>		24a. REC'D BY REGISTRAR DATE MAY 14 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					



Item 20b-Film MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

16012

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a Burial/Cremation permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Easton		c. LENGTH OF STAY IN 1b		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM?			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Memorial Hospital		3 days 4 hours		Henderson		RURAL			
e. NAME OF DECEASED (Type or print)		First	Middle	f. STREET ADDRESS		g. DATE OF DEATH		Month	Day	Year	
5. SEX		6 COLOR OR RACE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH		9 AGE (in years last birthday)		10 IF UNDER 1 YEAR		11 IF UNDER 24 HRS	
MALE white		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	January 6, 1921		38 yrs.		Months	Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Logging		Maryland		USA							
13. FATHER'S NAME		14. MOTHER'S MARRIED NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		Address	
Alfred Lord		Annie Weaver		YES WAR II		217-14-8752		Elizabeth Lord Henderson, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		835 X		DUE TO		Burned about 65% of his body		INTERVAL BETWEEN ONSET AND DEATH 26 days + 1/2			
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c)		(b)		DUE TO		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		Tractor turned over & caught on fire		20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
Hour 5 p.m.		5-2-79		Not while at work <input type="checkbox"/>		Farm		Baltimore, MD		MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE H.F. Metherison		EXAMINER'S NAME (Type) H.F.M. Metherison		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/9/59	
22a. BURIAL CREMATION REMOVAL (specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or county)					
Burial		5/11/59		Ridgely		Ridgely		Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
J. E. Boulaire Greensboro, Md.						Arthur S. Thomas					
VS AL5ME		SM 2/57		DATE MAY 11 '59							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6012 CERTIFICATE OF DEATH

Reg. Dist. No.

06013

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the physician. After this certificate has been signed by the attending physician and completely filled in by the physician, it should be filed with the registrar, or with the funeral director, if the registrars permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be used for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar, or with the funeral director, if the registrars permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Talbot		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN lb 35 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 149 S. Washington St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton	
3. NAME OF DECEASED (Type or print) JOSEPH VALENTINE MULLER		4. DATE OF DEATH May 12, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July 22, 1905
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) electrician		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Joseph Muller		14. MOTHER'S MAIDEN NAME Nina M. Stevens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-01-8675	
17. INFORMANT Mrs. Valentine Muller		Address Easton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Squamous cell carcinoma of larynx</i> DUE TO <i>190.3</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____ DUE TO _____ (c) _____			
INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Maryland
20f. (City or town) St. Michaels, Md.		(County) St. Michaels, Md. (State) Md.	
21. I certify that I attended the deceased from Sept 1, 1951 to 12 May 1951 , that I last saw the deceased alive on 12 May 1951 , and that death occurred at 10:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. Lane Wroth</i>		ADDRESS (Street, city or town, state) 10487 St. Michaels, Md. DATE SIGNED 5-15-59	
PHYSICIAN'S NAME (Type) Dr. R. Lane Wroth		Talbot St. Michaels, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 15, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Spring Hill Cemetery
22d. LOCATION (City, town, or county) Easton, Mar land		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice Newnam & Son		ADDRESS Easton, Md.	24a. REC'D BY REGISTRAR DATE MAY 19 '59
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knott</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06014

6013 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton.</i>		c. LENGTH OF STAY IN 1b <i>1 day.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>40 Easton</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				d. STREET ADDRESS <i>Dover Road</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>J. Price</i>		First	Middle	Last	4. DATE OF DEATH <i>Mullikin May 19 1959</i>	Month	Day	Year	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>September 25 1884</i>	9. AGE (In years lost birthday) <i>74 yr.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Former Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Clarence Mullikin</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Smith</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-34-7586</i>		17. INFORMANT <i>Mrs J. Price Mullikin, Easton Md. P.H.</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Hemorrhagic Pneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ DUE TO (c) _____									
INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>NONE</i>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>							
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from <i>4-30</i> , 19 <i>59</i> , to <i>5-19</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>5-19</i> , 19 <i>59</i> , and that death occurred at <i>2:15 PM</i> , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <i></i>									
DATE SIGNED <i>5-20-59</i>									
ACTUAL SIGNATURE <i>William L. Winters</i>		M.D. 2105 DOVER EASTON MD <i>5-20-59</i>							
PHYSICIAN'S NAME (Type) <i>William L. WINTERS</i>		EASTON MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 22, 59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Springfield</i>		22d. LOCATION (City, town, or county) <i>Easton</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bill Gaskin</i>		ADDRESS <i>Easton Md</i>		24a. REC'D BY REGISTRAR <i></i>		24b. REGISTRAR'S SIGNATURE <i>John S. House</i>			
				DATE <i>MAY 22 '59</i>					



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06015

6014 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg	
3. NAME OF (Type or print) Mr William Carlton Neal		d. STREET ADDRESS Rt. 2 - Box 249	
4. DATE OF DEATH May 6 1959		Month	Day
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH May 14 1890		9. AGE (In years, months, days, hours, minutes) lost birthday 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 0 0 0 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chesapeake Farmer		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME Andrew Neal		14. MOTHER'S MAIDEN NAME Mary Josephine Carson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 232-12-6019	
17. INFORMANT Mrs. Letha Neal, wife - son		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
Thoracic embolus/ 2600SS			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 May 1959 , to 19 May 1959 , that I last saw the deceased alive on 19 May 1959 , and that death occurred at 2 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE E.C.H. Schmidt		ADDRESS (Street, city or town, state) 219 S. Washington St. Federalsburg, Maryland	
DATE SIGNED 21 May 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 10, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM Roselawn Memorial Gardens		22d. LOCATION (City, town, or county) Bluefield, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE J.D. Hampton Son, Federalsburg Md.		24a. REC'D BY REGISTRAR MAY 11 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

L

T.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Part 12, 5-1-22 rd

06016

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be filed far use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		6015 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
Talbot				b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1B RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Memorial Hospital		d. STREET ADDRESS 11X-2	
3. NAME OF DECEASED (Type or print)		First Thomas	Middle Edmond	Last Nelson	4. DATE OF DEATH Month May Day 1 Year 1959
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 21, 1897	9. AGE (In years last birthday) 61 yrs.
Widowed <input type="checkbox"/>		Divorced <input type="checkbox"/>			IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Motor Equip op.		State Roads Commission		Md.	
13. FATHER'S NAME W. W. Nelson		14. MOTHER'S MAIDEN NAME Frances Thomas		12. CITIZEN OF WHAT COUNTRY? 23A	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 213-16-8331		17. INFORMANT Bertha P. Nelson, Cinnabrook Md.	
Yes, no, or unknown (If yes, give war or dates of service)				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Myocardial infarcts			
DUE TO		recent and old.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b)					
DUE TO					
(c)		Cerebral occlusion			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <u>4:12 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>219 S Washington St. 1 May 59</u>			
ACTUAL SIGNATURE <u>Bertha P. Nelson</u>		DATE SIGNED <u>1 May 59</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		22d. LOCATION (City, town, or county) (State) <u>Cinnabrook Co. Maryland</u>			
22e. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22f. DATE THEREOF <u>May 4-5-59</u>		22g. NAME OF CEMETERY OR CREMATORIAL <u>Chesapeake</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Baetz Jr. Baetz Bros. Centerville, Md.</u>		ADDRESS <u>Centerville, Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Trahan</u> DATE <u>MAY 4 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Trahan</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6022

CERTIFICATE OF DEATH

Reg. Dist. No.

06017

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Royal Oak		c. LENGTH OF STAY IN 1b 11 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Royal Oak		d. STREET ADDRESS /		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) FRANCIS M. O'BRIEN		First	Middle	Last	4. DATE OF DEATH May 27,	Month	Day	Year 19 59
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 12, 1876	9. AGE (In years last birthday) 82 yr	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) policeman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY/ U. S.		
13. FATHER'S NAME Michael O'Brien			14. MOTHER'S MAIDEN NAME Mary E. McCarthy			Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 126-14-0530		17. INFORMANT Mrs. Josephine O'Brien				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction - immediate DUE TO + 20.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atherosclerotic coronary heart DUE TO (c) chronic cardiac failure. Diabetes mellitus								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic cardiac failure. Diabetes mellitus								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 4-21-54 to 5-27-54 that I last saw the deceased alive on 5-27-54 , and that death occurred at 11 A.M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) St. Michaels, Md. DATE SIGNED 5-25-54								
ACTUAL SIGNATURE Guy M. Reeser, Jr.								
PHYSICIAN'S NAME (Type) Dr. Guy M. Reeser, Jr.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 30, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Memorial		22d. LOCATION (City, town, or county) (State) near Easton, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son			ADDRESS Easton, Maryland		24a. REC'D BY REGISTRAR DATE JUN 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for 7 days.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 20&21 Film 2425-14-59 ame

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

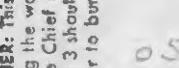
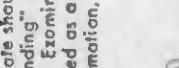
06018

Reg. Dist. No.

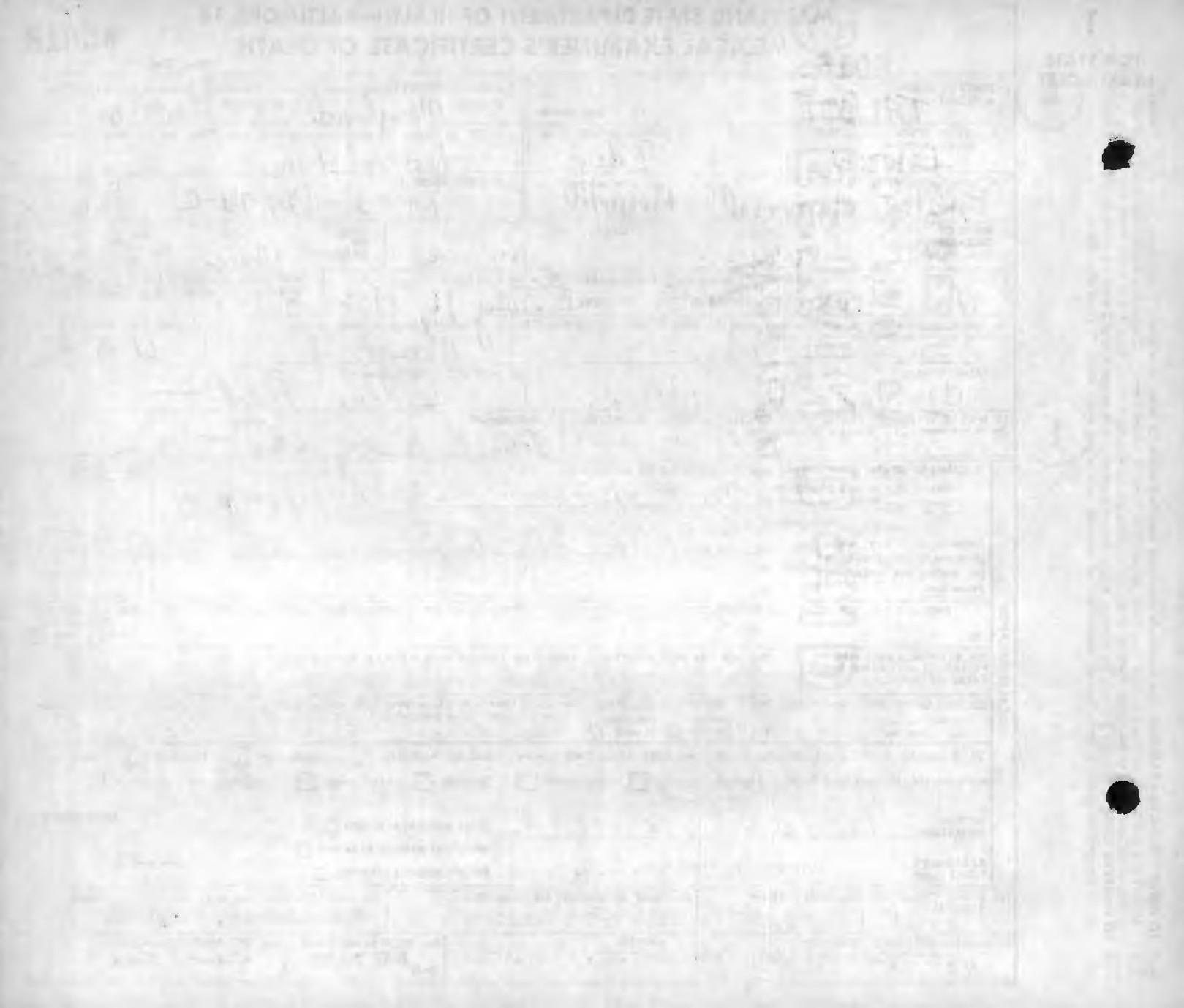
FOR STATE
HEALTH DEPT.



080



6016							
1. PLACE OF DEATH a. COUNTY TALBOT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		a. STATE MARYLAND		b. COUNTY CAROLINE			
c. LENGTH OF STAY IN 1b 8 days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		d. STREET ADDRESS RT #2 - Box 73-C		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTON Memorial Hospital		d. DATE OF DEATH Rosser		Month May		Year 5 1959	
3. NAME OF DECEASED (Type or print) CLAYTON Gregory		First Clayton		Middle D.			
4. SEX Male		5. COLOR OR RACE White		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH July 11, 1950		9. AGE (in years for birthday) 8 yrs.		10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PUBLIC SCHOOL STUDENT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clayton D. Rosser		14. MOTHER'S MAIDEN NAME Linda Patchett		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. None		17. INFORMANT Linda P. Rosser (mother) - Same		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 813X		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Multiple Fractures - Severe Head injuries Internal injuries		INTERVAL BETWEEN ONSET AND DEATH 9 days	
(b)		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hill Motor vehicle with bicycle		20c. TIME OF INJURY Hour 4 a.m. 4-27 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hill Highway		20f. (City or town) Federalsburg		(County) Caroline		(State) Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Dawson O. George		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5-5-59	
EXAMINER'S NAME (Type) Dawson O. George, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 8, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Hill Crest Cemetery		22d. LOCATION (City, town, or county) Federalsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		ADDRESS		24a. REC'D BY REGISTRAR MAY 7 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6017 CERTIFICATE OF DEATH

06019

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY TALBOT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN JB 5 hrs 25 mins	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL		e. STREET ADDRESS X CORDOVA	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MR. WILLIAM JAMES Sedgwick		First WILLIAM	Middle JAMES
Last Sedgwick		4. DATE OF DEATH MAY 15 1959	Month MAY
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH MAY 12, 1894		9. AGE (In years last birthday) 65 yrs. Months — 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY Houses	
10c. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MR. WILLIAM JAMES Sedgwick		14. MOTHER'S MAIDEN NAME GERTRUDE FERGUSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-30-7649	
17. INFORMANT Mrs. Susie Sedgwick, Cordova, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction		13 hours	
DUE TO 420.1			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (b)			
(c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Hour a. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) DOVER ST. (County) EASTON (State) M.D.	
21. I certify that I attended the deceased from 5-14 , 19 59 , to 5-15 , 19 59 , that I last saw the deceased alive on 5-15 , 19 59 , and that death occurred at 202 DOVER ST. EASTON, MD. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 202 DOVER ST. EASTON, MD. DATE SIGNED 5-15-59	
ACTUAL SIGNATURE Robert W. Trevor		PHYSICIAN'S NAME (Type) Robert W. TREVER	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 18, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL Spring Hill Cemetery		22d. LOCATION (City, town, or county) EASTON (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John D. Williams		24a. REC'D BY REGISTRAR Arthur S. Kline	
ADDRESS EASTON, MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	
DATE MAY 18 '59			

47. ДОВІРНІСТЬ ДО ПІДПРАВОВИХ ВІДЕОФІЛЬМІВ

ЧІТАВ ПО ЕТАПУ ІІІ

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